



HOSPITAL: ..... HEAD OF NEUROLOGY DEPARTMENT: .....

ADDRESS: ..... TELEPHONE NO: ..... E-MAIL: .....

NUMBER OF ACCREDITED CORE TRAINING POSITIONS: ..... NUMBER OF POSITION(S) TO BE RE-ACCREDITED: .....

**Probable Supervisors\* (2) FTE Date last attended RACP Supervisor Workshop**

1 ..... .....

2 ..... .....

**EMG Supervisor\*:** ..... **Level:**..... Hours/week spent supervising .....

**EEG Supervisor\*:** ..... **Level:**..... Hours/week spent supervising .....

*\*if insufficient space please attach complete list of supervisor, including the information requested above*

YEAR(S) FOR WHICH ACCREDITATION IS SOUGHT 2022 2023 2024 2025 2026

NO. OF INPATIENTS BEDS: .....QUALITY ASSURANCE PROG? YES NO

ON CALL FOR EMERGENCIES DURING NORMAL WORKING HOURS? YES NO

ON CALL FOR EMERGENCIES AFTER HOURS? ..... YES NO

NO. OF AMBULATORY CARE (OUTPATIENTS) CLINICS/WEEK: .....

AVERAGE NO. OF INPATIENT CONSULTATIONS/WEEK : .....

NO. OF PART-TIME NEUROLOGISTS IN THE DEPARTMENT: .....

NO. OF FULL-TIME NEUROLOGISTS IN THE DEPARTMENT: .....

NO. OF EEGs/WEEK ..... NO. OF EMGs/WEEK ..... NO. OF EPs/WEEK .....

YES NO CT SCAN (\*) .....

YES NO ANGIOGRAPHY: (\*) .....

YES NO READY ACCESS TO MRI: (\*) .....

YES NO WEEKLY NEURORADIOLOGY REVIEW MEETINGS: (\*) .....

YES NO MONTHLY NEUROPATHOLOGY TEACHING SESSION: (\*) .....

YES NO NEUROSURGERY SERVICE: (\*) .....

YES NO PSYCHIATRY SERVICE: (\*) .....

YES NO ONE SUPERVISED NEUROREHABILITATION SESSION/WEEK FOR 6 MONTHS:

*(\*) If off-site please nominate facility*

(\*) .....

**BRAIN SCHOOL:** Quarantined Time for trainee participation in National Brain School **Yes No**

*Location of video-conferencing facilities at hospital: (including contact details of technical support person):*

.....  
*Will Hospital or Area Health Authority allow access to these facilities at no cost to trainee: **Yes No***

**Other sub-specialty training available?** YES NO If YES, nominate specialties: .....

Please indicate any changes in resources since the last accreditation:

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**SIGNED:** ..... **NAME:** ..... **DATE:** ..... **POSITION:** .....

**Office Use Only:** Reaccredited:  Yes  No Date..... Accredited by: ..... (Please print name) .....

Comment:.....